

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022732

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 115

FILED JUN 18 1962

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Grundy | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Grundy | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Trenton | | c. CITY OR TOWN Trenton | |
| Length of stay in lb 12 years | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wright Mem. Hospital | | d. STREET ADDRESS (If outside, give location) 425 E. 17th St. | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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|--|----------------------------------|---|-------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last William A. McMillan | | 4. DATE OF DEATH Month Day Year June 11, 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-25-78 |
| 9. AGE (last birthday) 83 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teaching | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | |
| 11. BIRTHPLACE (City and state or country) West Newton, Pa. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME Joseph McMillan | | 13b. MOTHER'S MAIDEN NAME Albina Reed | |
| 14. NAME OF HUSBAND OR WIFE Katherine Christian | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. [REDACTED] | |
| 17. INFORMANT Clayton C. McMillan | | Address Leawood, Kans. | |

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| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

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|--|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from Dec. 17-1961 to June 11-1962 and last saw her alive on June 10-1962 Death occurred at 7:30 A. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|--|---------------------------------|--|---|--|
| 22a. SIGNATURE G. H. Haulers M.D. | | 22b. ADDRESS Trenton, Mo. | | 22c. DATE SIGNED 6-12-1962 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE June 13, 62 | 23c. NAME OF CEMETERY OR CREMATORY Centerview Cemetery | 23d. LOCATION (City, town, or county) (State) Centerview, Mo. | |
| 24. FUNERAL DIRECTOR Gipson-Whitaker | | 25. DATE RECD. BY LOCAL REG. 6-13-62 | | 26. REGISTRAR'S SIGNATURE Drene Fair |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leo H. Whitaker

Licensed Embalmer No. 4780

P. O. Address Clinton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.